

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
318

13918

State File No. _____

Registrar's No. **3653**

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR St. Louis, Mo.		c. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bethesda General Hospital		e. STREET ADDRESS (If rural, give location) 4471 Arco	
3. NAME OF DECEASED (Type or Print) a. (First) Albert b. (Middle) C. c. (Last) Spencer		4. DATE OF DEATH (Month) (Day) (Year) April 23 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 24, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager owner		10b. KIND OF BUSINESS OR INDUSTRY Confectionery	
11. BIRTHPLACE (City and State or Foreign Country) Flora, Illinois		12. CITIZEN OF WHAT COUNTRY? USA S. A.	
13a. FATHER'S NAME Emmett Spencer		13b. MOTHER'S MAIDEN NAME Katherine Swope	
14. NAME OF HUSBAND OR WIFE Wife- Emma Spencer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. I	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs. Emma Spencer	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Oedema ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Occlusion DUE TO Inter-arterial Heart Disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but related to the disease or condition causing death. Chronic Nephritis	
19a. DATE OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200	
22. I hereby certify that I attended the deceased from 20-Apr , 19 55 , to 4-23 , 19 55 , that I last saw the deceased on 4-23 , 19 55 , and that death occurred at 8:00 AM , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) George W. Bell		23b. ADDRESS 4501 Manchester	
23c. DATE SIGNED 23-Apr-55		24a. BOTTAL CREMATION, REMOVAL (Specify) Cremation	
24b. DATE 4/26/55		24c. NAME OF CEMETERY OR CREMATORY Missouri	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schnur	
DATE REC'D BY LOCAL REG. APR 25 1955		ADDRESS 3125 Lafayette Ave.	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Thomas R. Fenwick*

Licensed Embalmer No. *379*

P. O. Address *3125 Lida*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.